DiscoveryDental

DENTAL PATIENT INFORMATION

Today's Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Name that you prefer to be called: _____

Sex: ☐M ☐F Date of Birth: _____ Social Security Number: _____

Email address: _____

Address: _____ City _____State _____ Zip _____

Phone number: (h) _____ (c)_____ (w) _____

Preferred method of communication: ☐Phone call ☐Text message ☐Email

Marital status: ☐M ☐S ☐W ☐D

Are you presently employed? ☐Yes ☐ No ☐Full time ☐Part time ☐Unemployed ☐Disabled ☐Retired

Occupation: _____ Employer: _____

What is the reason for seeing us today? _____

Did you sustain an injury at work? ☐ Yes ☐ No

Are your injuries accident related? ☐ Yes ☐ No

If yes, please explain: _____

Who may we thank for referring you? _____

What can we do to ensure your experience with us is a pleasant one? _____

What was the reason you stopped seeing your previous dentist? _____

DOCTOR HISTORY

Primary Care or Referring Physician (Name & Phone): _____

Previous Dentist (Name & Phone): _____

EMERGENCY CONTACTS

Emergency Contact (Name & Phone): _____

SPOUSE OR SUBSCRIBER EMPLOYMENT INFORMATION

The following is for: ☐ patient's spouse ☐ the insurance policy holder

First Name_____ Middle Name_____ Last Name _____

Sex: ☐M ☐F Date of Birth: _____ Social Security Number: _____

Phone number: (h) _____ (c)_____ (w) _____

Address: _____ City _____State _____ Zip _____

Email Address: _____

Primary Dental Insurance

Insurance Name: _____ Phone #: _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

Group / Policy Number: _____Is this an employer or union policy? _____

Secondary Dental Insurance

Insurance Name: _____ Phone #: _____

Subscriber Name: _____ Subscriber Employer: _____

Subscriber Social Security #: _____ Subscriber Date of Birth: _____

Group / Policy Number: _____Is this an employer or union policy? _____

Primary Medical Insurance

Insurance Name: _____ Phone #: _____
Subscriber Name: _____ Subscriber Employer: _____
Subscriber Social Security #: _____ Subscriber Date of Birth: _____
Group / Policy Number: _____Is this an employer or union policy? _____

Do you have secondary medical insurance? _____

*Please present your insurance card to be photocopied for our record

MEDICAL HISTORY

Patient's Name: _____ Today's Date: _____
Date of Last Physical: _____ Weight: _____ Height: _____

Please check if you have ever had any of the following:

☐ Allergies (seasonal)	☐ Fainting / dizzy spells	☐ Neurological disorder
☐ Allergies to latex	☐ Glaucoma	☐ Osteoarthritis
☐ Allergies to medications	☐ Gall bladder problems	☐ Osteoporosis
☐ Acid Reflux/ GERD	☐ Herpes	☐ Persistent cough
☐ Anemia	☐ Heart disease	☐ Panic attacks
☐ Arthritis	☐ Heart Valve replacement	☐ Prosthetic joint
☐ Asthma	☐ Head / neck trauma	☐ Prosthetic heart valve
☐ Angina / Chest pain	☐ Heart attack	☐ Psychiatric care
☐ Anxiety	☐ Healing problems	☐ Psychological disorders
☐ Blood disease	☐ Headaches	☐ Pacemaker
☐ Breast Implants	☐ Heart murmur	☐ Radiation therapy
☐ Breathing problems	☐ Hepatitis	☐ Ringing in ears (Tinnitus)
☐ Bleeding disorder	☐ High blood pressure	☐ Rheumatic fever
☐ Chronic bronchitis	☐ High cholesterol	☐ Rheumatoid arthritis
☐ Chronic fatigue	☐ HIV / AIDS	☐ Shortness of breath
☐ Cancer or tumors	☐ Immune system disorder	☐ Sinus problems
☐ Circulation problems	☐ Infective endocarditis	☐ STD
☐ Congenital heart condition	☐ Jaundice	☐ Sleep apnea
☐ Diabetes	☐ Joint disease	☐ Stomach problems
☐ Drug / Alcohol abuse	☐ Joint replacement	☐ Stroke
☐ Depression	☐ Kidney disease	☐ Tuberculosis
☐ Dizziness	☐ Liver disease	☐ Thyroid disorder
☐ Earaches	☐ Lupus	☐ Ulcers
☐ Emphysema	☐ Mitral valve prolapse	☐ Other_____
☐ Epilepsy / seizures	☐ Neurological problems	
☐ Eating disorder	☐ Nervous disorders	

Do you have any allergies to?
☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Tetracycline ☐ Penicillin ☐ Local Anesthetic ☐ Sulfa
☐ Other allergies to medications (please list): _____
If you checked any of the above or have other medical conditions, please explain: _____
_____
_____

Number of alcoholic drinks per week: _____
Do you or have you ever smoked or used chewing tobacco? ☐ YES ☐NO If yes, how much and for how long? _____
Have you ever taken "bisphosphonates" (Fosamax, Actonel, Aredia, or Pamidronate?) ☐Yes ☐No
Do you need to be pre-medicated with antibiotics for dental treatment? ☐Yes ☐No

Women Only: Any chance you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

Please list ALL medications that you are currently taking:

☐ I take no medications currently

Medication	How often	For What	Amount taken	Doctor

I certify that the above is true to the best of my knowledge. I understand that if there are any changes to my health or medications, I will advise my dentist before beginning any treatment.

Patient Name: _____ Today's Date: _____

Patient Signature: _____

DENTAL HISTORY

Patient's Name: _____ Date: _____ Date of last dental exam: _____
Date of last cleaning: _____ How often do you brush? _____How often do you floss? _____
Please check all that apply to you:

☐ Bleeding gums ☐ Tooth removal ☐ Food gets stuck ☐ Accident in past ☐ Pain when chewing
☐ Tooth decay ☐ Braces ☐ Loose teeth ☐ Gum surgery ☐ Jaw surgery
☐ Broken teeth ☐ Sensitive teeth ☐ Toothache ☐ Bad breath ☐ Hot / cold sensitive
☐ Wear of teeth ☐ Crowding of teeth ☐ Dry mouth ☐ Other: _____

Are you happy with the way your teeth look? ☐YES ☐NO If not, why? _____

Are you dissatisfied with any of the following?

☐ Shape of teeth ☐ Crowding ☐ Silver fillings ☐ Color ☐ Length
☐ Spacing ☐ Old fillings ☐ Misalignment ☐ "Gummy" smile ☐ Old crowns
☐ Bad bite ☐ Other

Do you have any sores / spots in mouth that haven't healed for more than 2 weeks? ☐ Yes ☐ No

Please check all that apply to you:

☐ TMJ problems ☐ Jaw clicking ☐ Pain in jaw ☐ Grinding teeth
☐ Pain in facial area ☐ Numbness in fingers ☐ Tingling in fingers ☐ Dizziness (vertigo)
☐ Ringing in ears ☐ Numbness in face ☐ Neck or back pain ☐ Jaw clenching
☐ Tightness in face ☐ Wear a night guard ☐ History of jaw lock ☐ Difficulty chewing
☐ Difficulty opening mouth ☐ Pain behind eyes ☐ Trigeminal neuralgia ☐ Bells Palsy

Headache history: please check all that apply to you

Location of pain: ☐ Front of head / forehead ☐ Side of head ☐ Back of head
Intensity of pain: 0 (no pain) 1 2 3 4 5 6 7 8 9 10(extreme pain)
Do you suffer from morning headaches? ☐ Yes ☐ No ☐ Sometimes
Do headaches wake you up from sleep? ☐ Yes ☐ No ☐ Sometimes
Do you have nausea with headaches? ☐ Yes ☐ No ☐ Sometimes
Frequency of headaches: ☐ Constant ☐ Once/day ☐ Once every few days ☐ Once/week

Sleep Apnea Assessment: please check all that apply to you

Have you ever been diagnosed with Sleep Apnea? ☐ Yes ☐ No If yes, when? _____
Diagnosing physician: _____ Name of sleep center? _____
Please check all that apply to you:

☐ Snoring ☐ Gastro-esophageal reflux ☐ Insomnia
☐ Gasping for air during sleep ☐ Feel tired in morning ☐ Poor concentration
☐ Poor memory ☐ Difficulty breathing through nose ☐ Fatigue
☐ Trouble sleeping ☐ Nervousness ☐ Excessive daytime sleepiness
☐ Irritability ☐ Anxiety / depression ☐ Morning stiffness

Have you ever used a CPAP device and could not tolerate it? ☐ Yes ☐ No

If you were not able to tolerate the CPAP, why? _____

Office Financial Policies

We, the staff of Discovery Dental thank you for choosing us as your dental/health provider we are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact our office manager at 702.889.5000

INSURANCE

Discovery Dental will gladly submit dental claims on your behalf. However, filing your dental claim is not a guarantee of payment for services rendered. We can never guarantee coverage as quoted in our office, estimates and insurance payments are not guaranteed until the claims are processed. The patient portion of dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Discovery Dental staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Discovery Dental. However, if you are paid by the insurance company instead of Discovery Dental, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. Any charges not paid by your insurance becomes patient's responsibility. Be advised, even preauthorization of services does not guarantee payment from your insurance carrier. You will receive an explanation of benefits (EOB) from your insurance company within 30 to 60 days after the claim of services has been processed. If you have concerns about any items on your EOB, please call our office and we will gladly answer any questions that you may have.

TREATMENT PLANS

We will present patients with a TREATMENT PLAN ESTIMATE so that they can understand the estimated costs of recommended treatment prior to its start. The TREATMENT PLAN ESTIMATE is a good-faith attempt to predict the cost of your treatment based on the facts known to Discovery Dental when the estimate is furnished. As treatment progresses, the dentist may determine in consultation that a different approach or additional treatment may be necessary. When this occurs, be advised that patient financial responsibility may change.

PAYMENTS

We make payments as convenient as possible by accepting (cash, money order, all major credit cards, personal checks and outside financing.) Payment of services will always be due at the time of service.

DELINQUENT PAYMENTS

For any unpaid balances by insurances, the patient will need to contact our office within 30 days to make full payment or set up a payment arrangement Interest will incur if a balance remains unpaid after 60 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $50.00 plus any bank related charges. I also understand that I will bear the entire cost of collection, court costs and attorney fees on my account should this be required to collect outstanding balances at the sole discretion of the dental office.

MISSED APPOINTMENTS

We require notice of cancellations 48 hours in advance, our policy is to charge for missed appointments at the rate of $35.00 per each 30 minutes of missed appointment time. Please help us service you better by keeping scheduled appointments.

Patients Name_____ Today's Date: _____

Patient or Legal Guardian Signature_____

Privacy Practice Consent Form

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read the Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Compliance Officer: Tracey McDonald
Telephone: 702.889.5000 fax 702.889.6131
Address:7581 W. Lakemead Blvd., Ste 160, Las Vegas. NV 89128

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

Please list the full names of any individuals (family, friends, caretakers, etc.) that you would like to have access to your records. The persons listed below will also be able to call our office and discuss your treatment.

_____

_____

I, _____have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and heath care operations.

This authorization is valid from the date of my signature below and will remain in effect until terminated by me in writing.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____